



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

COPY

C. L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, Idaho 83720-0036  
PHONE: (208) 334-6626  
FAX: (208) 364-1888

April 9, 2009

Michael Day  
Independent Living Services Freedom  
P.O. Box 6395  
Boise, ID 83711

RE: Independent Living Services Freedom, Provider #13G031

Dear Mr. Day:

This is to advise you of the findings of the Medicaid/Licensure survey of Independent Living Services Freedom, which was conducted on April 9, 2009.

Enclosed is your copy of the Statement of Deficiencies/Plan of Correction Form CMS-2567, which states that no deficiencies were noted at the time of the survey.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

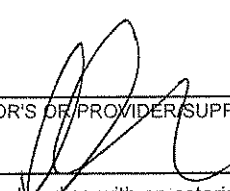
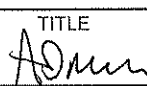
MICHAEL A. CASE  
Health Facility Surveyor  
Non-Long Term Care

NICOLE WISENOR  
Co-Supervisor  
Non-Long Term Care

MC/mlw  
Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/08/2009  
FORM APPROVED  
OMB NO. 0938-0391

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|--|---|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>13G031</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____   |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/09/2009</b>   |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>INDEPENDENT LIVING SERVICES FREEDOM</b>   |   |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>11577 WEST FREEDOM<br/>BOISE, ID 83704</b>                                   |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETION<br>DATE   |
| W 000  | <b>INITIAL COMMENTS</b><br><br>Independent Living Services- Freedom, is in compliance with the requirements of 42 CFR 483 Subpart I, Conditions of Participation: Intermediate Care Facilities for Persons with Mental Retardation.<br><br>The survey was conducted by:<br>Michael Case, LSW, QMRP, Team Leader<br>Sherri Case, LSW, QMRP | W 000  | <div style="text-align: center;"> <h1>RECEIVED</h1> <p>APR 09 2009</p> <h2>FACILITY STANDARDS</h2> </div>                |  |  |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE<br> |   |  |  |  | TITLE<br> |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Bureau of Facility Standards

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|--|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                            |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>13G031</b>             | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br>B. WING _____   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>04/09/2009</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>INDEPENDENT LIVING SERVICES FREEDOM</b> |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>11577 WEST FREEDOM<br/>BOISE, ID 83704</b> |  |  |
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| M 000  | <p>16.03.11 Initial Comments</p> <p>Independent Living Services- Freedom, is in compliance with the requirements of Idaho Department of Health and Welfare Rules, Title 03, Chapter 11, "Rules Governing Intermediate Care Facilities for the Mentally Retarded (ICF/MR)."</p> <p>The survey was conducted by:<br/>Michael Case, LSW, QMRP, Team Leader<br/>Sherri Case, LSW, QMRP</p> | M 000  |  |  |

Bureau of Facility Standards

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

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If continuation sheet 1 of 1